The Belly Studio
2520 E. 6th St.
Tucson, AZ 85716
520 207 8098

Client Intake

Today's Date _____

Last Name First Name

Contact Information:

Address Gender:

Address 2 Marital Status

City State Postal Country

Cellular: Website:

Work: Birthdate

Home: Email:

Fax: Age

Emergency Contact:

Name: Relationship:

Cellular:

Employment Information:

Occupation: Employer:

Additional Information:

How did you find out about us? Check all that apply:

☐ Personal Referral ☐ Doctor Referral ☐ Advertising ☐ Location ☐ Web ☐ Other

May we send you notices about events, specials, etc.?

Interests & Hobbies:

Aerobics	_____	Meditation	_____	Reading	_____
Back Care Classes	_____	Mountain Biking	_____	Workshops	_____
Computer Work	_____	Pain Management	_____	Yoga	_____
Courses	_____	Pre/Post Natal Class	_____	Zumba	_____
Cycling	_____	Spinning	_____	Other	_____
Dance	_____	Triathalons	_____	Other	_____
Golf	_____	Weight Lifting	_____	Other	_____
Gyrotonic	_____	Weight Loss	_____	Other	_____

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Health Screening

Please fill out this form to the best of your ability and sign the statement at the bottom of the Health Screening Session as in all sections. If you have any questions, please feel free to ask.

General Health (Check One): Excellent Good Fair Poor

Are you experiencing any physical problems? If so, please explain: _____

Are you currently or have you previously been diagnosed with any of the following? Please check all that apply.

____ Allergies	____ Foot / Ankle Pain	____ Osteoarthritis
____ Arthritis	____ Hand / Wrist Pain	____ Osteopenia
____ Asthma	____ Headaches	____ Osteoporosis
____ Auto Accident	____ Heart Attack	____ Pacemaker
____ Back Pain	____ Heart Disease	____ Pregnancy (Current)
____ Bone Fracture(s)	____ Herniation	____ SacroIlliac Dysfunction
____ Bowel/Bladder Changes	____ High Blood Pressure	____ Seizure Disorder
____ Bronchitis	____ Hip Pain	____ Scoliosis
____ Cancer	____ Hyperglycemia	____ Shoulder Frozen
____ Cervical Lumbar Disc	____ Hyperthyroidism	____ Shoulder Impingement
____ Cervical Problems	____ Hypothyroidism	____ Spinal Fusion (S)
____ Diabetes	____ Implants / Bresat	____ Shoulder Pain
____ Disc Herniation	____ Implants Other	____ Stenosis
____ Dizziness	____ Knee Pain	____ Stress
____ Elbow Pain	____ Leg Pain	____ Surgery (ies)
____ Epilepsy	____ Neck Pain	____ Thyroid Dysfunction
____ Fainting Disorder	____ Numbness or Weakness	____ Whiplash

Are you currently receiving professional health care services? (i.e. Chiropractic, Medical; Massage; Therapy; Physical Therapy, Etc.)

_____

_____

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General

Previous Injuries:

Previous Surgeries:

Medications:

Previous Experience with Pilates:

Personal Fitness Goals: :

Hobbies/Recreational Activities and Frequency:

Is there anything else that you feel we should know about or have not been asked? If so, please esplain:

I, the undersigned, do hereby certify that I have completed the above information and know it to be truthful and accurate to the best of my knowledge.

Signature: _____ Date: _____

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Release and Waiver:

I, _____ voluntarily desire to participate in physical and/oir rehabilitative exercise training classes conducted by The Belly Studio, L.L.C. and Arlene Corcoran, C.P. T., located at 2520 E. 6th St., Tucson, AZ 85716, and understand and agree with the following:

1. I assume full responsibility while voluntarily participating in any training class at my sole risk and shall abide by and all rules and regulations for use of the facility which may be promulgated from time to time by its owner or The Belly Studio Pilates Studio.

2. I am aware that there exists the possibility of certain conditions occuring during or following training and/or exercise. These conditions include, but are not limited to: mild or light headedness, fainting, abnormalties of blood pressure or heart rate, ineffective heart function and in rare instances, heart attack and stroke. The reaction of the cardiovascular system to such activity cannot be predicted with complete accuracy.

3. It is strongly recommended that I receive medical clearance from my private physician prior to starting this or any exercise training program. This program can be designed for persons with known heart disease or those with disorders which require medical supervision however, those persons should have a direct physician referral. The Belly Studio, L.L.C. reserves the right to deny services to those without their physicians' written consent and or referral.

4. I expressly agree that I have been informed that the program involves possible risks and all exercises shall be undertaken at my sole risk and that neither The Belly Studio, L.L. C., nor its officers, directors, agents or employees shall be liable to me or any other person, for any claims, demands, injuries, damages, actions or causes of action, whatsoever, to my person or property arising out of or connect to services and/or exercises having direct relation to this facility. I do hereby release and discharge The Belly Studio, L.L.C. thereof from all claims, demands, injuries, damages, actions, or causes of action and from all acts of active or passive negligence on the part of The Belly Studio, L.L.C. or their officers, directors, agents or employees.

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Today's Date _____

Last Name First Name

I HAVE READ THE ABOVE STATEMENT AND UNDERSTAND THE ABOVE CONDITIONS.

Client's Signature: _____ Date: _____

Witness: _____ Date: _____

If the person signing is under age 21, there must be consent by a parent or guardian, as follows:

I hereby certify that I am the parent or guardian of _____, named above, and do hereby give my consent without reservation to the foregoing on behalf of this person.

Parent of Guardian's Signature:

_____ Date: _____

Parent of Guardian's Printed Name:

_____ Date: _____

Cancellation Policies:

24 Hour Cancellation Policy for Private, Weekly Sessions.

I am aware that if I do not cancel my training appointment before 3 pm on the day previous to my appointment, I will be responsible for 50% of the payment for the session.

I, the undersigned, do hereby certify that I have completed the above information and know it to be truthful and accurate to the best of my knowledge

Client's Signature: _____ Date: _____

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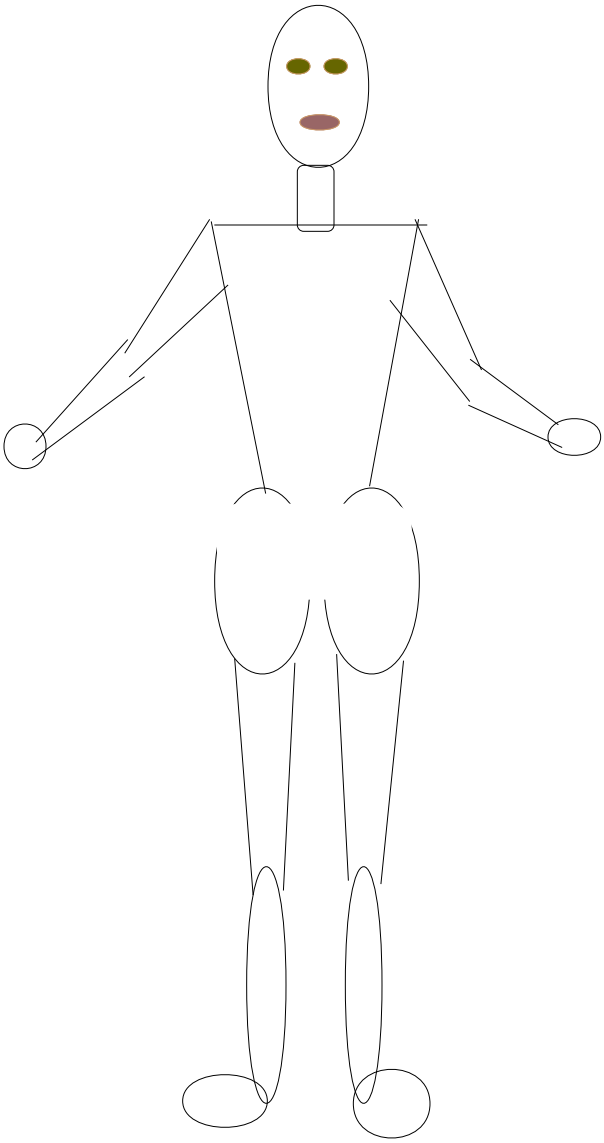
Circle the areas of your body that give you pain or concern.

Front:



Back: